STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF DENTISTRY
(615) 532-3202 or 1-800-778-4123
www.Tennessee.gov/health

APPLICATION INSTRUCTIONS FOR LICENSURE AS A DENTIST BY CRITERIA (RECIPROCITY)

I. THE APPLICATION PROCESS

Application, practice, and renewal as a dentist are governed by T.C.A. § 63-5-101, et seq. and Rules 0460-1-.01, et seq.

1. All **application fees are non-refundable.**
2. All documents and fees required to be submitted by you, or which must be requested from the appropriate institutions in the application process, must be mailed directly to:

> **Tennessee Board of Dentistry**
> **227 French Landing, Suite 300**
> **Heritage Place MetroCenter**
> **Nashville, TN 37243**

3. Allow fourteen (14) working days for information mailed to our Office to be received and placed in your file. Federal Express or special courier services will not reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred.
4. **We will discuss application status with the applicant or applicant's spouse only**. **Please inform hospitals, employers, recruiters, referral companies, or insurance companies that application status updates must be obtained from you.**
5. If the application is not complete upon receipt by the Board's Administrative Office, a deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board's Administrative Office within sixty (60) days from the date of the initial deficiency letter. **Files not completed within sixty 60) days will be closed**.
6. It is recommended that you do **NOT** make arrangements to practice as a Dentist in Tennessee until you are granted a license by the Tennessee Board of Dentistry.
7. **NOTE: If you are applying for a Limited License, Limited Educational License or Dual Degree (M.D./D.D.S.) licensure, please read the following:**

   Limited License – This process is applicable to a Dentist who graduated from a non-ADA accredited program with a degree substantially equivalent to either a D.D.S. or D.M.D. degree and has successfully completed a graduate training program in a recognized specialty branch of dentistry from an advanced specialty program accredited by the ADA. This type of license limits the practice location to ADA accredited institutions, dental education programs or in federally-designated health professional shortage areas. Proof of employment to practice in any of these locations is required upon initial application and subsequent renewal of this license. This type of licensure requires a special type of application. Please request this application from our office or download the application from the Board's website at Tennessee.gov/health.

Limited Educational License - This process is applicable to a Dentist licensed in another state and who will be teaching in a dental educational institute. This type of license limits the practice location to programs offered by the educational institution. Upon termination of faculty appointment, the license is void. This type of licensure requires a special type of application. Please request this application from our Office or download the application from the Board's website at Tennessee.gov/health.

Dual Degree Licensure - This process is applicable to a Dentist who is licensed in Tennessee as a Medical Doctor and who possesses an active dental license which is in good standing in at least one (1) other state. You may use this Application for Dual Degree Licensure application. **However**, the supporting documentation is different and you must apply for your specialty certification at the same time you apply for your dual degree license. Please refer to Rule 0460-2-.02 for more information.

II. CHECKLIST – USE TO COMPLETE YOUR APPLICATION

NOTE: All submissions must be executed and dated less than one (1) year before receipt, or the documents will be rejected by the Board.

		Done
1.	Tape to the first page of the Application a passport-size photograph of yourself (taken within the last twelve (12) months); then sign your name on the front of the photograph.	___
2.	Complete pages 1 through 6 of the Application. Sign page 6 of the Application in the presence of a Notary; then, mail all six (6) pages to the Board's Office.	___
3.	Complete and mail **Attachment 1** to the institution from which you completed your Dental program to request that an official transcript be mailed directly to the Board of Dentistry.	___
4.	If you **are** or **have ever been** licensed, certified, registered, or permitted by any state to practice as a Dentist (or any other health care professional), you must complete and mail **Attachment 2** to each and every state. **Attachment 2** may be duplicated to accommodate each request.	___
5.	Submit a copy of all current and valid licenses to practice dentistry which you currently hold.	___
6.	Please complete and mail **Attachment 3** to the American Dental Association to have your National Board scores forwarded directly to the Board of Dentistry.	___
7.	Submit two (2) **Original** letters of recommendation from licensed dental professionals who can attest to your good moral character. These letters must identify the individual(s) as licensed dental professionals, be submitted on the signator's letterhead, and bear the original signature of the author.	___
8.	Copy the front and back of your current CPR card and tape the copies to a full- sized sheet of paper. Submit these copies with your 6-page Application to the Board.	___
9.	Attach proof of U.S. or Canadian citizenship or evidence of being legally entitled to live in the U.S. (e.g. copy of birth certificate, voter's registration card, naturalization papers, or current visa status.)	___
10.	**Paperclip a check or money order in the amount of Five Hundred Sixty Dollars ($560) made payable to the "Board of Dentistry" to the front of the Application.**	___
11.	**If any of your answers to the "competency questions" on pages 4 and 5 of the Application were in the affirmative, please submit a separate document to explain the situation.** Please read the instructions on page 4 of the Application carefully. You must answer "Yes","No",or "N/A" to **every** question.	___
12.	Proof of intent to actively practice or teach in Tennessee by submitting proof of employment as a dentist, in a private practice or with a college or university, or by submitting proof of starting a private dental practice in Tennessee.	___
13.	If you have ever taken the Southern Regional Testing Agency (SRTA), North East Regional Board of Dental Examiners (NERB), the Western Regional Examining Board (WREB) or the Central Regional Dental Testing Service (CRDTS) examination, proof of passage of any of these examinations must be received directly from the testing agency.	___

14. Proof of practice in private dental practice or teaching in an ADA accredited institution in another state or states for at least five (5) years **or** proof of successful completion of an examination administered by another state which is substantially equivalent to the examination required for initial licensure in Tennessee (as determined by the Board) and proof of practice in a private dental practice or teaching in an ADA accredited institution for at least two (2) years ___

15. Applicants who have failed three (3) times the National Board or any regional examination must successfully complete a remedial course of post-graduate studies at a school accredited by the ADA before consideration for licensure by the Board. The program director of the post-graduate program must provide written documentation of the content of such course and certify successful completion. ___

16. **A criminal background check is required.** For instructions to obtain a criminal background check, ***click here*** or go to the Noteworthy section of the Board's website. ___

17. Complete and submit the Practitioner Profile Questionnaire along with your Application. **Your Application file will not be processed for licensure until a completed Questionnaire is received.** You are required by law to keep your profile up-to-date while you maintain an active license. Failure to do so may subject you to disciplinary action. ___

IT'S THE LAW! If you change your mailing address, you must notify the Board's Administrative Office, in **writing,** within thirty (30) days. Failure to abide by this law could effect your license, since failure to receive the renewal application does not relieve you of the responsibility for timely renewal.

Additional certifications or permits that you can submit an application to add to your general dentist license, if you qualify (see Rules 0460-2-.06 and/or 0460-2-.07):

1. Specialty Certification
2. Limited Conscious Sedation Permit
3. Comprehensive Conscious Sedation Permit
4. Deep Sedation/General Anesthesia Permit

IMPORTANT: You must have a license issued by the Tennessee Board of Dentistry in your possession before you may lawfully practice as a Dentist in Tennessee.

TAPE A CURRENT, FULL-FACE PHOTOGRAPH (SIGNED BY APPLICANT ON THE FRONT OF THE PHOTO) HERE

FOR OFFICIAL USE ONLY

FEES IF APPLYING BY CRITERIA (RECIPROCITY)

1201-001	$ 550
1201-006	$ 10
	$ 560

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF DENTISTRY
(615) 532-3202 or 1-800-778-4123
www.Tennessee.gov/health

APPLICATION FOR LICENSURE AS A DENTIST BY CRITERIA (RECIPROCITY)

Please complete each question and return the form, supporting documents, and the Five Hundred Sixty Dollar ($560) application fee to the above address.

PERSONAL INFORMATION

PLEASE PRINT IN INK

Name: _____
Last First Middle Maiden (if not used as your middle name)

Social Security Number: ____-____-____ U.S. Citizen: Yes ____ No____

Date of Birth: _____ Place of Birth: _____

Mailing Address: _____

_____

_____

_____ Zip _____

Practice Address: _____

_____

_____

_____ Zip _____

County (TN Applicants Only): _____ Phone: Home: (____) _____

Gender: (optional-for statistical purposes only) Office: (____) _____

Female _____ Male_____

Have you ever been known by any other names besides what is listed above? Yes ___ No

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known. _____

_____

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space. (Send **Attachment #1** to the educational institution where you completed your dental program.)

From: Mo./Yr.	To: Mo./Yr.	Educational Institution	City, State	Degree Earned	Year Graduated

Please complete your entire employment history starting with the most current position first. Use the back of this page, if you need additional space. Dates of employment must be included and proof of practice/employment must be submitted.

Company/ Employer:	Address: (Street, City, and State)	Position:	Duties:	Dates From: Mo./Yr.	Dates To: Mo./Yr.

CERTIFICATION INFORMATION

List below **ALL states, countries, or provinces in which you have ever been or are currently licensed, permitted, or certified** as a Dentist. Additional pages may be added, if necessary. [Submit a copy of **Attachment #2** to all such states, countries, or provinces regarding such licensure, certification, or permit.] Use the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below **ALL** states, countries, or provinces in which you hold or have ever held a license, certification, or permit as a health professional other than a Dentist. [Submit a copy of **Attachment #2** to all such states, countries, or provinces regarding such licensure, certification, or permit.] Use the back of this page if you need additional space. **If this section does not apply, mark N/A.**

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

	YES	NO
1. Are you certified by the National Boards?		
2. Have you ever previously applied for a dentist, dental hygiene, or dental assisting license in Tennessee?		
(If you answer "Yes" to at least one of the following questions, proof of passage must be received from the testing agency or state board.)		
3. Have you ever taken the Southern Regional Testing Agency (S.R.T.A.)?		
4. Have you ever taken the North East Regional Board of Dental Examiners (NERB)?		
5. Have you ever taken the Western Regional Examining Board (WREB)?		
6. Have you ever taken the Central Regional Dental Testing Service (CRDTS)?		
7. Have you ever taken a state licensure examination?		
Regional or State Exam(s) Taken: _____		
Exam Site(s): _____		
Date Exam(s) Taken: _____		
8. Do you have any pending disciplinary charges or action or any current investigation by a disciplinary authority?		

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet**.** ***In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application.***

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
   a. The cognitive capacity to make appropriate clinical diagnosis (if necessary), exercise reasoned judgments, to learn, and keep abreast of developments in your profession;
   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disability, HIV disease, tuberculosis, drug addiction, and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.	**YES**	**NO**
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice dentistry with reasonable skill and safety?	___	___
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	___	___
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	___	___
2. Do you currently use chemical substances?	___	___
If yes, do they in any way impair or limit your ability to practice dentistry with reasonable skill and safety?	___	___

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]

COMPETENCY INFORMATION
(continued)

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.	YES	NO
3. Are you currently engaged in the illegal use of controlled substances?	___	___
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	___	___
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	___	___
5. If you have held or applied for a license or certificate to practice as a Dentist in any state, country, or province, has, it been, or was it ever, denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
6. If you have ever had staff privileges at any hospital or health care facility, have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	___	___
7. Have you ever failed a dental examination? (National Boards, regional or state) If yes, how may times have you failed? _____	___	___
8. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic offense?	___	___
9. Have you ever applied for and been denied a state or federal controlled substance certificate?	___	___
If you have possessed such a certificate, has the certificate ever been revoked, suspended, restricted, otherwise disciplined, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
10. Have you ever been rejected or censured by a dental society?	___	___
11. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered <u>against</u> you;	___	___
b. Have you ever entered into a settlement or had any legal, adverse action brought <u>against</u> you; or	___	___
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	___	___
12. If you have ever held a license or certificate in ANY health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
13. Are you currently being treated for the addiction to alcohol or drugs?	___	___
14. Are you currently being treated for a psychological condition?	___	___
15. Have you ever been dropped, suspended, expelled, or disciplined by any school or college for any cause?	___	___

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____,
(Applicant's Name) *(City)* *(State)*
being duly sworn and identified as the person referred to in this application and signed photo, attest to the truth of each statement made in said Application. I further swear that I have read and understand the law and the Rules and Regulations, which regulate the dental professions, and agree to abide by them in the practice as a Dentist in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a Dentist.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

Sworn to before me this _____ day of _____, _____.

Affix Seal Here

_____
NOTARY PUBLIC

My Commission Expires _____

ATTACHMENT # 1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF DENTISTRY
1-888-310-4650 ext. 25073
www.Tennessee.gov

EDUCATION VERIFICATION

APPLICANT: Supply the information requested in this box and then mail this entire form to the school at which you completed your Dental program. NOTE: Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee.

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a Dentist in the State of Tennessee. The Board of Dentistry requires verification of educational attainment. Please forward an original transcript bearing the institution's official seal to the Board's address listed below.

Applicant's Full Name: _____
(Last) (First) (Middle/Maiden)

Applicant's Address: _____

_____

_____

Applicant's Social Security Number: _____ - _____ - _____

Applicant's Student Identification Number: _____

Year of Graduation: _____

Degree Conferred: _____ Date Degree Conferred: _____

Please forward an original graduate transcript bearing the institution's official seal to:

Tennessee Board of Dentistry
227 French Landing, Suite 300
Heritage Place MetroCenter
Nashville, TN 37243

Thank you for your cooperation and prompt response.

_____ _____
Applicant's Signature Date

ATTACHMENT #2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF DENTISTRY

ENDORSEMENT FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box, then, mail one (1) form to the licensure board in EACH state where you hold or have ever held a license to practice any profession. (Copies of this form can be used.) NOTE: Some states require a fee for providing endorsement information. To expedite your application, you may wish to contact the applicable state(s).

To Be Completed By Applicant (Please Print In Ink)

I, the undersigned applicant, was granted a **(circle one)** license or certificate to practice _____
(Profession)
numbered _____ on _____ in the State of _____. The Tennessee Board of Dentistry requests that I submit evidence of the current status of that license in your state.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Dentistry.

_____ _____ _____
Date Applicant's Signature Applicant's typed or printed name

To Be Completed by Administrative Office of State Licensure Board:

Name In Full as it appears on License/Certificate or Permit:

_____
(First) (M.I.) (Last)

License/Certificate/Permit Number: _____ Profession: _____

Date Issued: _____ Expiration Date: _____

Basis of Issuance: _____ Endorsement/Reciprocity with _____
(check one) (State)
_____ Written Examination _____

The License is currently active and registered? Yes _____ No _____

Is there any derogatory information on file? Yes _____ No _____ If yes, please attach supporting documentation.

_____ _____ _____
Authorized Signature Title Date

Please mail directly to: **Tennessee Board of Dentistry**
227 French Landing, Suite 300
Heritage Place MetroCenter
Nashville, TN 37243

State Seal

_____
State

ATTACHMENT # 3

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF DENTISTRY

NATIONAL BOARD EXAMINATION VERIFICATION

Please complete the top portion of this form, attach a **MONEY ORDER** OR **CERTIFIED CHECK in the amount of Fifteen Dollars $15.00** MADE PAYABLE TO THE AMERICAN DENTAL ASSOCIATION, and mail it to the address below.

Send to:

DEPARTMENT OF TESTING SERVICES
AMERICAN DENTAL ASSOCIATION
211 EAST CHICAGO AVENUE, SUITE 1846
CHICAGO, IL 60611

TO BE COMPLETED BY APPLICANT (PLEASE PRINT IN INK)

Dear National Board Official:

I am applying for a license to practice as a Dentist in the State of Tennessee. The Tennessee Board of Dentistry requires that a copy of my scores be **forwarded directly to their** office by the National Boards.

Applicant's Name _____
(First) (M.I.) (Last)

Social Security No.: ____ - ____ - ____ Date National Certified _____

Name of Institution from which you graduated: _____

Date you graduated from the Dental Program: _____

Year of Birth: _____

PLEASE MAIL SCORE VERIFICATION DIRECTLY TO:

TENNESSEE BOARD OF DENTISTRY
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METROCENTER
NASHVILLE, TN 37243

TENNESSEE DEPARTMENT OF

HEALTH

MANDATORY

PRACTITIONER

PROFILE QUESTIONNAIRE

PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq, LAWS OF TENNESSEE

FOR

LICENSED HEALTH CARE PROVIDERS

FOREWORD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: http://tennessee.gov/health**.**

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

TABLE OF CONTENTS

SECTION I: GENERAL INSTRUCTIONS

- **Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.**
- **Incomplete or illegible profiles will be returned to the provider for resubmission.**
- **Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **Provide only information for the previous ten (10) years where indicated on the questionnaire.**
- **Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- **You may have completed a similar questionnaire for another state's licensing board. If so, Tennessee law still requires you to complete and submit this form.**
- **If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.**

- **Mail the completed ORIGINAL profile questionnaire <u>within thirty (30) days of its receipt by the provider</u> to:**

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
1-800-778-4123
Local - (615) 532-3202

- **<u>Keep a copy of the questionnaire for your records.</u>**

✓CHECKLIST

Before you mail your questionnaire:

- ☐ Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?

- ☐ Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?

- ☐ Have you retained a copy of your signed questionnaire?

SECTION II:

COMPLETING THE PROFILE QUESTIONNAIRE

QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in "N/A" for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

VII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

VIII. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19,1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED. To find out the threshold amount established by your board, consult your board's web page at www.state.tn.us/health/ or call 1-800-778-4123. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

IX. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name _____ **License #** _____
Profession _____

SECTION III:

HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER: _____ PROFESSION: _____

B. SOCIAL SECURITY NUMBER: _____ (**This will not be published as part of the profile or website).**

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

_____
(LAST) (FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)

FORMER NAME(S):

_____
(LAST) (FIRST) (MIDDLE)

_____
(LAST) (FIRST) (MIDDLE)

D. MAILING ADDRESS:

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).

_____
(PRACTICE NAME)

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

E. TELEPHONE:(_____)_____**(This will not be published as part of the profile or the web site).**

F. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.

1. _____
2. _____

G. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:

1. _____
2. _____

Practitioner's Name _____ **License #** _____
Profession _____

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ **License #** _____
Profession _____

III. SPECIALTY BOARD CERTIFICATIONS

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES ❒ NO ❒

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

If "YES", list the title of the appointment and name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			
4.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES ❒ NO ❒

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

	Name of Hospital	City/State
1.		
2.		
3.		
4.		
5.		

Practitioner's Name _____ **License #** _____
Profession _____

B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES ❒ NO ❒
If "YES", list each plan in which you currently participate:

Name of TennCare Plan
1.
2.
3.
4.
5.

VI. FINAL DISCIPLINARY ACTION (See Instructions)

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name_____ **License #**_____
Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by <u>any</u> hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
1.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name_____ **License#**_____
Profession _____

VII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s): YES ❒ NO ❒

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
2.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
3.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒

VIII. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. §63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.		
2.		
3.		

IX. OPTIONAL INFORMATION

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	**ORGANIZATION**
1.		
2.		
3.		
4.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

_____ Date:_____
(Signature of Provider)

YB/G6019027/RTK-ms.70